Medically Complex Children's Waiver Application Instructions

(Please read the following information carefully)

The Utah State Legislature authorized the Medically Complex Children's Waiver (the program) as an ongoing program (HB100, 2018 General Session). Children enrolled in this program will have access to respite services, as well as traditional Medicaid services. **The current application period is July 1 – July 31, 2021.**

In order to qualify a child must meet the following criteria:

- Be 18 years old or younger (the individual is eligible until turning 19)
- Have 3 or more specialty physicians in addition to their primary care physician
- Show medical complexity involving 3 or more organ systems
- Demonstrate a level of medical complexity based on a combination of need for device-based supports, high utilization of medical therapies, and treatments and frequent need for medical intervention
- Children who are not meeting age appropriate milestones for their activities of daily living; this includes eating, toileting, dressing, bathing and mobility.
- Have a level of disability determined by the State Medical Review Board

To be considered for participation, this application must be complete and include required attachments. We will be requesting a copy of the most recent history and physical or Well Child Check from the child's physicians. This documentation must include past medical and surgical history, problem or diagnosis list, active medication list, allergies, vital signs, physical exam and a plan of care. We will also be having the Primary Care Provider fill out a certification form.

The information submitted must be for the 24 month period immediately preceding the month of program application (or less if the applicant is less than 24 months old). All healthcare information will be verified through medical documentation by Medicaid's clinical staff.

If you have multiple children in your family for whom you are applying, you will need to complete a separate application for each child.

Please read all application instructions thoroughly and carefully.

In addition to this application you will be required to provide additional supporting documentation. This documentation must be sufficient to validate the information in this application. Without the supporting documentation your application will NOT be considered complete.

Your supporting documentation must include:

- ***Authorization to Disclose Health Information or provide a copy of the child's most recent history and physical by the Primary Care Provider.*** **a copy of the history and physical or Well Child Check completed within the last 24 months;**
- **If the applicant has an Individualized Education Program (IEP) please include the IEP with the submitted application**

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To be considered for participation, applications must be complete. INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED. Applications will be accepted online, mail or fax using the following contact information:

WEBSITE: http://medicaid.utah.gov/ltc/mccw

FAX: 801-323-1593

MAIL: Utah Department of Health
Medically Complex Children's Waiver
Division of Medicaid and Health Financing
Bureau of Long Term Services and Supports
PO Box 143112
Salt Lake City, Utah 84114-3112

- **If you submit the application via mail it must be postmarked with a date during the application period. (Please be aware that this will require you to go the post office and request that the envelope be postmarked).**

Please be aware determining eligibility for this program is a two-step process that includes: 1) Program eligibility and 2) Financial eligibility. The purpose of this application is to determine if your child meets specific program requirements. To determine if your child meets financial eligibility you will be required to complete a Medicaid application with the Department of Workforce Services (DWS). Only the child's income and assets will be used to make the financial eligibility determination.

If your child is selected for participation in the program, you will be contacted by the Department about completing the financial eligibility portion of the application. Additional information on financial eligibility can also be found at:
https://medicaid.utah.gov/apply-medicaid

For more information, please contact the Utah Department of Health.
Toll-free Phone: 1-800-662-9651, option 5
Email: mccw@utah.gov

Applications WILL NOT be accepted via email. Please do not submit any private health information to this email address.

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Applicant Information

Please fill out as much of this section as possible so that we can identify and contact you regarding the status of your application.

Child's Name: _____
Last *First* *M.I.*

Parent's Name: _____
Last *First* *M.I.*

Child's Date of Birth: _____ Child's Gender: ☐ Male ☐ Female

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: ( ) _____ Alternate Phone Number: _____

Email Address: _____

Medical Intervention, Consultation and Conditions

Who is your child's Primary Medical Provider? _____

What is the frequency your child has seen this Provider? _____

Please list the last time your child saw this Provider? _____

Please provide a list of your child's care team that your child has seen in the last year. (These are in addition to your primary care provider). If additional lines are required please attach a separate sheet:

Name	*Specialty*	*Condition or diagnosis being treated*	*Date last seen by provider*
Name	*Specialty*	*Condition or diagnosis being treated*	*Date last seen by provider*
Name	*Specialty*	*Condition or diagnosis being treated*	*Date last seen by provider*

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Name	*Specialty*	*Condition or diagnosis being treated*	*Date last seen by provider*
Name	*Specialty*	*Condition or diagnosis being treated*	*Date last seen by provider*
Name	*Specialty*	*Condition or diagnosis being treated*	*Date last seen by provider*

Please list any additional diagnosis:

_____

_____

_____

_____

_____

Please indicate if your child has prolonged dependence for Medical Devices, Treatments, Therapies or Subspecialty Services

Please indicate if your child has prolonged dependence (more than 3 months) on medical devices or treatments to support adequate organ function. Please do not include periods of increased illness in your response as it is anticipated that such needs will be temporary (less than 3 months).

☐ Tracheostomy with or without humidification

☐ Implantable technology; shunts, pumps (e.g. insulin, baclofen, vagal nerve stimulator, etc.)

☐ Daily ventilation; invasive (through a tracheostomy) or noninvasive (cpap, bipap, etc.)

☐ Daily oxygen use

☐ Daily suctioning; nasal, oral, pharyngeal or tracheal

☐ Daily airway clearance; cough assist, vest or manual chest physiotherapy

☐ Daily monitoring; cardiorespiratory, pulse oximeter, apnea, glucose, etc.

☐ Daily use of urinary catheter; vesicostomy, indwelling or intermittent

☐ Daily use of colostomy or complex bowel program

☐ Daily bowel or bladder incontinence (child must be greater than 3 years of age), this does not include urge incontinence or nocturnal enuresis

☐ Nightly nocturnal enuresis (child must be greater than 5 years of age)

☐ Daily wound care or sterile dressing changes (NOT including trach, IV, stoma or feeding tube sites)

☐ Daily tube feeding; bolus or continuous, gastric or jejunal

☐ Severe seizures requiring at least minimal intervention at least monthly

☐ Infusions through a central venous catheter (e.g., PICC, Broviac, Port-a-Cath, etc.) at least monthly

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Please indicate if your child has ***dependence* on at least 5 daily, scheduled medications.**

☐ Daily administration of 5 or more routine medications

Medication Name:	Medication Schedule:

Please indicate if your child has any of the following functional or developmental limitations and/or prolonged dependence on supportive or mobility-related devices (e.g., braces, AFOs, wheelchairs, shower chairs, gait belts, etc.)

Please List Devices: _____

_____

Daily prolonged oral feeding includes not able to self-feed, arching or stiffening during feeding, refusal of feeding, texture aversion, difficulty chewing, coughing or gagging, frequent spitting or vomiting, excessive food drooling, etc.

☐Daily prolonged oral feedings lasting more than 30 minutes

☐Occupational Therapy at least monthly

☐ Physical Therapy at least monthly

☐ Speech Therapy at least monthly

☐ ABA Therapy at least monthly

☐ Child is legally deaf and/or blind

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Please select the item below that best describes your child's mobility.

☐ **The child is completely immobile**
Non-ambulatory and is not able to make slight changes in positioning without assistance, cannot transfer to a chair and maintains a lying position.

☐ **The child's mobility is very limited**
Able to make slight changes in body or extremity position but unable to make frequent or significant changes without assistance. Cannot bear own weight and/or must be assisted into the chair or wheelchair.

☐ **The child's mobility is slightly limited**
Makes frequent though slight changes in body or extremity position independently. Walks or crawls occasionally during the day, but for very short distances, with or without assistance.

☐ **The child's mobility is not limited**
Walks or crawls frequently and reposition without assistance.

Please indicate with an "X" in the appropriate column your child's ability to perform age-appropriate self-care tasks.

Self-Care Skill	Independent or Age-Appropriate	Needs Helps (Supervision or Minimal Physical Assistance)	Dependent (Full Assistance by Another)
Bathing			
Dressing			
Toileting			
Transferring from a bed to a chair			
Walking			
Climbing Stairs			
Eating/ Self Feeding			

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Please answer the questions below to provide information regarding how your child's complex medical conditions have impacted family caregivers and finances in the past 12 months.

Please select the most applicable answers from the items below:

1. How often does your child sleep 6 hours or more, without requiring care?

☐ Often (4 or more times per week)

☐ Sometimes (2 or more times per week)

☐ Seldom or Never (1 or fewer times per week)

2. How often does the primary care giver engage in activities that support their own health and well-being as primary care giver?

☐ Often (1 or more times per week)

☐ Sometimes (2 or more times per month)

☐ Seldom or Never (less than 1 time per month)

3. How often do other's (family members, volunteers, school, etc) assist in caregiving of the medically complex child?

☐ Often (1 or more times per week)

☐ Sometimes (2 or more times per month)

☐ Seldom or Never (1 or fewer times per week)

If you are applying for multiple children in your family please indicate below:

5. ☐ I have additional children served on the Medically Complex Children's Waiver or I am applying for multiple children.

Please list the names of the additional children:

_____

6. The ANNUAL out-of-pocket medical expenses for my Medically Complex Child is:

☐ Less than $7,500

☐ Between $7,501 and $10,000

☐ Between $10,001 and $15,000

☐ Between $15,001 and $20,000

☐ Between $20,001 and $25,000

☐ More than $25,001

The next questions are related to how your child's complex medical conditions have impacted your family's employment experience.

Please Check ALL that Apply

☐ A parent or guardian has had to decrease the number of hours worked to care for the applicant

☐ A parent or guardian had to change jobs with reduced hours or pay to care for the applicant

☐ A parent or guardian had to quit a job to care for the applicant

The next question is used to identify the medical service coverage resources available to your child.

Please check the box below if your child has medical insurance coverage. If your child has medical insurance coverage please list the insurance providers below.

☐ My child has medical insurance coverage

This can include coverage by publicly funded programs such as Medicaid, CHIP, Medicare, etc.

Insurance Provider:

Insurance Provider: _____

_____

Application Submission

By submitting this application I certify that the information provided is accurate to the best of my knowledge. I understand that intentional mis-statements may be grounds for rejection of my application, or termination of my enrollment in the program. I also understand that my application must be complete in order to be considered, and that if my application is not complete it will be rejected.

_____ _____

Date *Signature*